Part A: Systems Assessment

1. Description of criteria for admission to Psychiatric Residential Treatment Facility (PRTF).

For admission to a PRTF, the youth must have a covered DSM-IV diagnosis (referenced in Administrative Rule #37-89-103: see Appendix 1) as the principal diagnosis and a determination that s/he meets the criteria as seriously emotionally disturbed (SED). The course of treatment and response to treatment are thoroughly documented in records consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and/or state licensing requirements. In addition, the following must be met:

- Symptoms or functional impairments of the individual's emotional disturbance are of a severe and persistent nature and require 24-hour treatment under the direction of a physician.
- Less restrictive services are documented as insufficient to meet the individual's severe and persistent clinical and treatment needs. The prognosis for treatment at this residential level of care can reasonably be expected to improve the individual's condition or prevent further regression, based upon the physician's evaluation.
- If compromised academic performance is part of the clinical presentation, an individualized educational plan (IEP), as guaranteed under the Individuals with Disabilities Education Act (IDEA 97), is in place from the individual's school district, **or** the treatment plan includes a referral for an IEP, in writing, to the home district.
- A comprehensive discharge plan and estimated length of stay are developed upon admission, identifying the appropriate services at a less restrictive level of care.
- The treatment plan includes the active participation of the parent(s) or legal guardian and all active preadmission caregivers. See current admission criteria: Appendix 2.

2. a. Description of PRTF capacity and usage in Montana:

The description of a PRTF is consistent with that used for the demonstration project: "Non-hospital facilities with a provider agreement with a State Medicaid Agency to provide inpatient services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or any other accrediting organization with comparable standards recognized by the State. PRTFs comply with Conditions of Participation on the use of restraint and seclusion."

PRTFs meeting demonstration definition in MT	PRTF beds licensed & certified for Medicaid Under-21 Benefit **(Total: 257 beds)**	Occupancy rates*	Average length of stay in days: SFY 2006 Medicaid		# of youth in PRTF out-of-state services (Medicaid reimbursed)	
3	– Acadia HealthCare: 85 – Yellowstone Boys & Girls Ranch (YBGR): 112 – Shodair: 60	94.6% (aggregate)	In-State 117	Out-of-State 150	Point in time 8/31/06: 57**	TOTAL FOR SFY 2006: 109
*Occupancy rates reflect an average for the 6-month period between April 2006 – September 2006. ** The State Fiscal Year (SFY) runs from July 1 – June 30						

b. Characteristics of Medicaid youth served in PRTFs during State Fiscal Year 2006 follow.

Race/Ethnicity PRTF Population	In State	Out-of-State	2000 Census (Universe: ages 0-20)
African American	0.8%	3.2%	0.4%
American Indian or Alaskan Native	25.6%	22.1%	9.4%
Asian or Pacific Islander	0.5%	0.0%	0.6%
European American/Caucasian	70.1%	71.6%	85.8%
Hispanic	3.0%	3.2%	3.1%

Diagnosis/Disorder	In-State	Out-of-State
Bipolar Disorders	28%	30%
Anxiety Disorders	13%	9%
Other Mood Disorders	29%	23%
Oppositional Defiant	11%	8%
Intermittent Explosive	5%	4%

Diagnoses/Disorder	In-State	Out-of-State
Psychotic Disorders	4%	13%
Attention Deficit/ Hyperactivity	3%	2%
Other MH Disorders	3%	8%
Reactive Attachment Disorder	4%	1%
Eating Disorders	–	1%
Sexual Offending	–	1%

Children's Mental Health Bureau (CMHB) MMIS Data

Age	In-State	Out-of-State
6	0.8%	–
7	1.3%	1.1%
8	4.6%	–
9	4.8%	–
10	5.1%	–
11	5.1%	1.1%
12	6.1%	4.2%
13	8.6%	4.2%

Age	In-State	Out-of-State
14	12.2%	21.1%
15	15.0%	7.4%
16	15.2%	20.0%
17	8.1%	23.2%
18	9.1%	13.7%
19	4.1%	3.2%
20		1.1%

CMHB MMIS Data

Gender	In-State	Out-of-State
Male	55%	65%
Female	45%	35%

3. If the States contracts with PRTF providers that reside out of State, provide a description of the contractual obligations of the PRTF and any limitations on purchase of beds.

Montana does not contract with specific out-of-state PRTF providers, but out-of-state facilities interested in serving Montana youth must enroll as Montana Medicaid providers. Eligibility is contingent on: proof of licensure, certification, JCAHO or CARF accreditation or registration according to Montana state laws and regulations; a W-9; and agreement to meet all specified conditions regulating the specific provider type, program and/or service. Providers must complete a Montana Medicaid Provider Enrollment Form, which serves as a contract between the provider and the Department. Each provider is assigned a Montana Medicaid provider number for each type of service provided, which are used in all Medicaid correspondence. **Limitations: They have to be turned down by all three in-state facilities and have received preapproval from the Department's Utilization Review contractor, currently First Health of Montana.** There are no limitations on purchase of out-of-state beds, presuming sufficient funding and beds.

4. Provide a description of the various systems of care that are utilized by the State to provide services to youth. These systems include but are not limited to, juvenile justice, foster care and education. Describe the services currently provided in these systems.

The **Children's Mental Health Bureau** (CMHB) designs, manages and evaluates the Medicaid Mental Health Service Plan and the Children's Mental Health Service Plan (CMHSP). The CMHSP serves youth with SED who are not eligible for Medicaid or the State Children's Health Insurance Plan (SCHIP). Those enrolled in the CMHSP have annual incomes of 150% of the Federal Poverty Level or less. CMHB's primary objective is ensuring appropriate and adequate mental health care services to youth served in and out of state. Quality of care is measured in part by preserving families through delivery of community-based services. **Services**: The Mental Health Service Plan provides outpatient therapy, therapeutic group homes, therapeutic foster care, acute hospitalization, residential treatment, family-based services, psychiatric and psychological services, and medication for SED youth. The CMHSP provides for limited services including outpatient therapy, psychiatric and psychological services and medication.

During State Fiscal Year (SFY) 2006, in-state PRTFs served 394 Montana youth and out-of-state PRTFs served 109. Approximately 55% of youth served in-state and 65% of those served out-of-state are male. Over ¾ have one of four diagnoses: bipolar disorder, anxiety disorder, other mood disorders, and oppositional defiant disorder. The most common age for youth served by in-state PRTFs is 16; the most common age for in out-of-state PRTFs is 17. Nearly all of those served by in-state PRTFs are Caucasian (70.1%) or American Indian (25.6%). The remaining 4.3% is comprised of very small numbers of African American, Asian and Hispanic youth. The population served by out-of-state PRTFs is relatively consistent: 93.7% of those served are either Caucasian (71.6%) or American Indian (22.1%); the remaining 5.3% is almost equally divided between Hispanic and African American youth.

Juvenile Justice: Each of Montana's 22 judicial districts has a youth court with authority to make out-of-home placements for treatment or to a secure correctional facility. Use of in-state group homes is most common, accounting for approximately 68% of non-shelter home placements (SFY 2004). **Services**: Youth are referred to individual and/or family counseling regardless of mental health diagnosis, and are given the *Back on Track* assessment, which measures risk and protective factors and is used to build a case management plan. It does *not* diagnose mental illness. To place a child out-of-home, the law requires a placement committee to review the case and make recommendations to the probation officer and judge. If a child is determined to meet the criteria for SED, s/he can be placed in a group home or shelter care.

The Youth Services Division of the Department of Corrections has two youth correctional facilities. Pine Hills is a 140-bed secure care program for adjudicated delinquent males ages 10 through 17. Riverside is a 20-bed secure care program for adjudicated delinquent females ages 10 through 17. **Services:** Both facilities offer counseling via cognitive restructuring principles, opportunity for participation in culturally appropriate, life skills and work programming. Pine Hills offers treatment for chemical dependency and sex offenders. Both have registered nurses on staff seven days a week, and contract for medical, dental, chemical dependency and psychiatric services. The Youth Community Corrections Bureau includes Juvenile Parole, aftercare coordinators and youth transition centers. Juvenile Parole Officers coordinate with Institutional Case Managers to plan reentry. Aftercare Coordinators track placement plans, schedule pre-placement meetings, work with staff, parole officers, contracted service providers, families and others.

Foster Care: Child Protective Services (CPS) policies provide social workers general information about the mental health system. They arrange for assessments, evaluations and therapy. **Services**: Adequacy of services depends on the strength of the local mental health system. Montana served about 2,200 youth through its foster care system during SFY 2006. CPS pays room and board for youth in therapeutic foster care, but does not track the number of youth receiving mental health services.

Education: Comprehensive School and Community Treatment (CSCT) provides school-based mental health services for youth with SED using local school tax dollars to match Medicaid dollars. CSCT is administered through the Department of Public Health and Human Services, working cooperatively with the Children's Mental Health Bureau and the Office of Public Instruction. Montana has 120 school teams in 42 cities, serving elementary, middle school and high school youth. **Services**: Licensed professionals and behavior specialists provide a range of mental health services including individual, family and group counseling, social skills training, behavioral training and support.

State Children's Health Insurance Plan (SCHIP): SCHIP is low-cost, private health insurance for income-eligible Montana youth up to age 19. It covers office visits, vision and hearing exams, prescriptions, physical health services, limited substance abuse and mental health services. SCHIP's extended plan for mental health covers eligible SED youth. **Services**: The SCHIP covers: pharmaceuticals; residential treatment, hospitalization or therapeutic group home (21 days annually); individual and/or family psychotherapy office visits (20 per year). The extended plan includes 30 additional days in a therapeutic group home, 30 days of therapeutic in-home family care, 120 hours each for day treatment and community-based psychiatric rehabilitation and support, 30 more office visits and 144 hours of respite care. As of 9/15/2006, 13,162 youth were enrolled in SCHIP, of whom 35 were enrolled in the expanded mental health plan.

5. Explain how these systems are currently integrated financially, functionally, and organizationally, and comport to best support youth in the community.

Systems integration is in its early stages. Systems addressing the needs of youth with SED remain largely independent financially, functionally and organizationally. Each has different missions, resource pools, goals and measures of success. All strive for the most efficient package of services for youth and overarching work is ongoing in terms of integrating consistent cross-system assessment tools and finding ways to collect and use cross-systems data. Local and state-level agencies and programs work through formal and informal channels to coordinate services to youth, and generally come to the table to work in the best interests of the child and to develop comprehensive treatment plans with common goals.

6. Describe how functional outcomes are currently measured for youth served in PRTFs, and other systems providing care to the target population. Functional outcomes are not currently measured by the following systems: children's mental health, including PRTFs; foster care; and SCHIP and juvenile corrections. Juvenile justice tracks outcomes by compliance with prescribed mandates. In education, functional outcomes are measured in terms of academic progress.

7. Provide the criteria for determining who is eligible under each of these systems.

- **Children's Mental Health Services (Medicaid):** The child must be diagnosed with an SED and must be Medicaid eligible. For youth 6 – 19, households must be at or below 100% of the Federal Poverty Level.
- **Juvenile Justice:** Law enforcement, schools, parents and others may refer juveniles who have committed status offenses (e.g., curfew violations, runaway or unmanageable behavior), misdemeanors or felony offenses.
- **Juvenile Corrections:** A youth commits a serious legal infraction and is remanded to the custody of the state youth corrections system.
- **Foster Care:** Youth are removed from their families and placed in the custody of the State because they have been abused, neglected and/or abandoned by parents or caretakers, or because of other serious family problems.
- **Education**: There are no specific eligibility criteria. All Montana youth, including those with disabilities, are entitled to a free appropriate public education.
- **SCHIP (**including SCHIP's Mental Health Services Plan): The child/youth must be a Montana resident and a US citizen or qualified alien. S/he cannot be currently insured, must have been uninsured for one month and be ineligible for Medicaid. The household must meet income guidelines (101 – 150% of federal poverty level for the family's size). Parents cannot be employed by the State or the University system.

8. Provide a description of progress being made by the applicant to further integrate these

systems of care and explain the barriers in creating an integrated system of care.

A Systems of Care Initiative has been in place since 2001, when collaboration among child-serving state agencies and other stakeholders was mandated by the Montana legislature. Additional legislation in 2003 established the Children's System of Care Committee (SOC) and a Multi-agency Memorandum of Understanding (52-2-303 MCA). The SOC Committee was charged with developing and coordinating an integrated service support system for youth under 18 who have a diagnosed SED, living in, or about to be placed in, an out-of-home setting, and needing assistance from more than one state agency. The committee is comprised of about 30 members, including SED youth and their parents, representatives of OPI (education), youth justice and other state-level child serving agencies, providers and advocates. **Barriers** to integration include gaps in state-level and local care continuums for SED youth, difficulty braiding categorical funding streams, lack of consistency in evaluation and assessment tools, and lack of ability to collect and share data across systems. See 52-2-303 MCA: Appendix 3.

9. Provide a description of funding issues that affect the ability to deliver a comprehensive and coordinated system of care

PRTFs have been the primary providers for youth with a diagnosed SED who require an institutional level of care. The 1915(c) HCBS regulations have not allowed PRTF level of care for budget neutrality calculations. Another funding issue is the specificity of Medicaid relative to services that can be provided. For example, Medicaid cannot pay for non-medical transportation, room and board or respite. Montana ranks 5th in the Nation on state Medicaid expenditures for mental health, but there are more youth than ever accessing services, which stretches an already tight budget. Since there are limited funds to track outcomes and provide functional analyses, the ability to refine services to fit the needs of clients is also limited. The match for Medicaid services comes from the State's General Fund tax dollars, which are historically limited.

10. Describe any gaps in the ability to provide a comprehensive set of services and supports

Significant gaps rise from the fact that this is a frontier state, encompassing 145,552 square miles. Montana is the 4th largest state in the nation, but home to just 935,670 inhabitants (2005 Census estimates). This equates to 6.4 persons per square mile, with more than 65% of the population clustered around eight population centers. Small populations make it challenging to build and maintain a comprehensive roster of services because economy of scale is difficult to achieve. This forces consumers and providers to travel long distances to the nearest population centers to give or receive services. Extreme poverty, lack of reliable transportation, lack of public transportation, and the high cost of gasoline, add to the transportation challenges. Other gaps result from the limited beds in Montana's three PRTFs, which deny admission if there isn't available space, an appropriate treatment program or ability to ensure safety for the youth or others. Those denied admission must seek treatment in other states.

11. Describe gaps in ability to provide services in home and community settings.

Even in Montana's largest communities, little is available in terms of crisis response and assessment for youth with a diagnosed SED and their families. Crisis response often means choosing between the sheriff or the emergency room. Afterward, there are few support services for parents who need assistance. There are no 24-hour services to assist with coping, and no services to help a family build a safety net from existing resources. No funding or mechanisms are available to provide respite care or short-term relief for the family caregivers. Finally, caregivers typically lack the training that would help them understand behaviors, treatment regimens, medications and/or behavior management techniques. Often, parents feel compelled to put a child in PRTF

simply because they have limited skills or resources available to maintain the child at home.

Addressing the gaps: Montana, in partnership with the Crow Tribe, began addressing the gaps in home and community based services when the State received a multi-year Systems of Care (SAMHSA) grant in September 2004. The funds are being used to develop local infrastructure for a statewide system of care for youth with an SED and their families. The SOC Committee and CMHB have actively encouraged development of local interagency teams known as Kids Management Authorities (KMAs), multi-agency community teams comprised of parents, youth, public and private child-serving agencies, youth corrections, courts, tribes, providers and advocates. KMAs provide local infrastructure for wraparound services and partner with the State to provide information on systemic needs. They participate in policy development and help educate legislators on the needs of youth with SED and its impact on families. (See Appendix 4 for an Introduction to Kids Management Authorities.)

Disproportionate minority representation: Montana's largest minority, American Indians, represents approximately 9.4% of the state's population of youth aged 0 – 20. They are over-represented among those served by in-state PRTFs at 25.6%, and out-of-state PRTFs at 22.1%. There are few African Americans in Montana, but their representation in PRTFs is also disproportionate: 0.4% of all Montana youth ages 0 – 20 are African American, as compared to 0.8% served in-state and 3.2% of those served by out-of-state PRTFs. In this case, percentages are misleading: 3.2% represented three youth. During SFY 2006, 21 American Indian youth were served out of state, as were 68 Caucausian and three Hispanic youth. In-state PRTFs served 276 Caucasians, 101 American Indians, 12 Hispanic, three African American and two Asian youth. There is duplication in the numbers, because some were served at in- *and* out-of-state facilities.

12. Provide an assessment of cultural and linguistic competency of HCBS system. Describe gaps in ability to provide culturally and linguistically appropriate services and supports

Linguistic competency: Virtually all Montanans are fluent in English. According to 2000 Census data, only 5.2% of the entire population (aged 5+) speaks a language other than English, and just 1.5% of the population speaks English less than "very well." Among all Montana youth ages 5 – 17, 95.2% speak *only* English (2000 Census). Kids Count data (2004) reveals that just 1% of all youth have difficulty speaking English. If a youth or the family is less than fluent in English, the home and community-based systems of care makes accommodations through translators brought in on a case-by-case basis. Sign language interpreters are also available through the Department for youth or parents who are deaf or hard of hearing. The Department will ensure all necessary services and supports at such time as the need arises.

Cultural competency: A Cultural Competency Survey targeting providers and policy makers was developed through a partnership between Bach-Harrison Evaluators and a systemwide workgroup that included the Crow Tribe. The survey was administered to the SOC Committee in July 2006. It revealed that: 96% of respondents had received training around cultural issues in the past year; 96% attend relevant meetings and conferences about the populations served; 91% agreed/strongly agreed that family is defined differently in different cultures and that they should respect the different roles genders play in cultures; and 87% read relevant media about the populations they serve. The survey identified the following **gaps**: lack of a formal process for evaluating cultural competency at the agency level; lack of training around broader definitions of culture (e.g., age, gender, education); and lack of knowledge of socioeconomic and cultural norms.

Part B: Development Plan

1. Goal: State the overall goal of the program.

Goal: The goal of AMP Montana (**A**lternatives for **M**edicaid to **P**RTFs in **Montana**) is to preserve families and prevent youth with Serious Emotional Disturbance (SED) from entering PRTFs by offering alternative home- and community-based services in the least restrictive placement closest to home.

2. Problem Statement: Define the problem(s) that prevent the target population(s) from receiving comprehensive, integrated HCBS.

Problem Statement: Without an 1915(c) HCBS waiver, a combination of factors prevents Montana's youth with SED from receiving comprehensive, integrated community-based services. These include a sparse population scattered over a geographic area so immense that crossing Montana equates to traveling from Washington DC to Chicago. A lack of crisis intervention, ongoing education and support services for families coupled with lack of funding for flexible community-based services all coalesce into conditions in which there is often no choice but to send youth away from their homes and communities to receive mental health treatment. On an individual family level, lack of savings, financial resources and health insurance often mean that parents find themselves without any other recourse for providing appropriate mental health care for a child with SED.

Target Population: Medicaid-eligible youth between the ages of 6–16, who meet the criteria for SED, and demonstrate such complex health and mental health needs that they require ongoing residential treatment or are at imminent risk of admission to a PRTF. These youth could remain in their homes and/or communities given availability of an appropriate package of services designed to address their multiple needs. Eligible youth will also have a viable, consistent living environment with parents, guardians or caregivers who are able and willing to participate in the AMP project and maintain the child in the home or community.

Geographic Target: The first year of the AMP Montana demonstration project will target Yellowstone County (Billings), then expand to include five of the most populous counties in Montana. Under consideration are Missoula, Lewis and Clark (Helena), Silver Bow (Butte), Cascade (Great Falls) and Flathead (Kalispell) counties were chosen because services are available, and they've historically demonstrated the highest incidence rates of eligible youth served by in- and out-of-state PRTFs. In SFY 2006, 62.7% of all youth with SED served by in-state PRTFs and 55.1% of all served by out-of-state PRTFs came from these six counties.

Geographic Variations in Populations	Cascade - Great Falls	Flathead - Kalispell	Lewis & Clark – Helena	Missoula – Missoula	Silver Bow – Butte	Yellowstone - Billings
Total Population 2005	79,569	83,172	58,449	100,086	32,982	136,691
Population Age 6–16	11,333	11,367	7,904	12,077	4,334	19,149
Percent Male	52%	50.6%	51%	52%	51%	51%
% Caucasian	86.8%	96.7%	93.1%	90.9%	93%	88.4%
% Native American	5.7%	1.2%	2.6%	3.4%	2.9%	4.7%
% African American	1.2%	0.3%	0.3%	0.4%	0.2%	0.7%
% Other	1.8%	0.5%	1.0%	1.9%	1.3%	2.4%
% 2 or more	4.5%	1.4%	2.9%	3.4%	2.5%	3.9%
Age 6-16 as % of pop.	14%	13.7%	14%	12%	13%	14%

Geographic Variations	Cascade	Flathead	Lewis/Clark	Missoula	Silver Bow	Yellowstone
Age 5-17 in poverty '03	16.3%	15.5%	13.1%	16.4%	19.6%	14.5%
% of all youth served by in-state PRTFs 2006	10.3%	4.9%	11.7%	7.9%	10.1%	17.8%
% of all youth served out of state SFY 2006	9.2%	3.7%	11.0%	9.2%	4.6%	17.4%
Data Sources: 2005 Census Estimates www.ceic.mt.gov and Northwest Area Foundation www.nwaf.org and Children's Mental Health Bureau MMIS System						

– **Incidence and Prevalence of Mental and Physical Health Needs of the SED Population:**

Mental and Physical Health Needs as Reflected by Services Provided: Population: Medicaid/PRTF Recipients SFY 2006			
Mental Health Service by Percent of Youth Served		Physical Health Services by Percent of Youth Served	
Individual Outpatient	9.5%	Disease Management	8.1%
PRTF	8.5%	Outpatient Hospital	7.0%
Youth CASE Management	8.0%	Inpatient Hospital	6.9%
Psychiatry	7.6%	Physician Services	6.8%
Group Outpatient	4.5%	Other Medical Services	5.9%
Therapeutic Family/Foster Care	2.3%	Dental	4.8%
Therapeutic Youth Group	1.5%	Lab/X-ray	4.6%
Comprehensive School and Community Treatment (CSCT)	0.9%	Eye glasses	4.2%
		Optometric	4.1%
		Drugs (Pharmacy)	3.3%
		Federal Health Clinic Services	1.0%
		Ambulance	0.8%
		Indian Health Services	0.4%
		Durable Medical Equipment	0.1%
		Physical Therapy	0.1%

A review of youth aged 16 or younger with services received while in residential treatment identified additional services including those listed in this table. Data Source: MMIS

In 2004, the Montana Children's Initiative completed a survey of High Cost (HC) SED youth, defined as those requiring $6,000+ a month in services. This effort was expanded in 2005 to include additional youth in high-cost placements, follow-up with youth originally surveyed, and a random sampling of youth receiving Low Cost (LC) community-level services. All services were funded by Montana Medicaid. The LC group sampled in the second phase included youth with similar risk factors and diagnoses to the HC group, but who had not required residential treatment. The survey covered 40 HC youth, aged 5–18, and 44 LC youth aged 4–18. Information was collected from clinical charts, family members, service providers, the Child and Family Services Division, youth court personnel, and schools. Comparative analysis revealed that individuals in

2004-05 Study of "High" and "Low" Cost Youth with SED

Physical Health Issues	**High Cost**	**Low Cost**
Suspected Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effect (FAE)	–	34.1%
Substance use/abuse	25%	22.7%
Chronic Illness	15%	18.2%
Currently prescribed medications for a physical health condition	15%	15.9%
Diagnosed FAS or FAE	12.5%	4.6%
Diagnosed Neurological Disorders	10%	13.6%

both groups tended to access a menu of services and to have more than one health condition. More than half (54.2%) of the HC sample and 42.2% of the LC sample reported physical health issues, with issues including those demonstrated in the table on the preceding page.

Need for the demonstration project in the geographic area(s): Yellowstone County will be the initial demonstration site. It is the most populous county in the state, and has, over time, demonstrated the highest incidence of youth with SED who must access residential services. In SFY 2006, 16.3% of all youth with SED who received Medicaid services were from this area. Yellowstone County also has the most active and highly developed KMA in Montana, and is large enough to offer most HCBS services needed to create comprehensive packages. The other counties under consideration for the AMP Demonstration account for an additional 41.1% of all youth with SED served in Montana during SFY 2006, have services available as well as are home to high service populations.

Youth with SED Receiving Medicaid Services

County	SFY 2006	% of MT Total
Cascade	1,117	10.9%
Flathead	699	6.8%
Lewis & Clark	745	7.3%
Missoula	1,060	10.3%
Silver Bow	595	5.8%
Yellowstone	1,674	16.3%
6-County Totals	**5,890**	**57.5%**
Montana Totals	10,253 (includes duplication)	

– **Comprehensive Systems Assessment Approach in Demonstration Development**

Montana will comply with all evaluation requirements for the Medicaid Demonstration project. A comprehensive systems assessment is underway through the 2004 Systems of Care SAMHSA grant. The intent of that grant was to create the sustainable community infrastructure that would give families and youth with SED options other than residential treatment. ORC Macro is the national evaluation contractor for SAMHSA, and will evaluate the State of Montana and at the local level in Systems of Care Implementation sites. These include the Crow Nation, Billings, Missoula, Helena, Butte, Havre/Rocky Boys and Fort Belknap reservations. The information gathered from these tools will incorporated in the AMP Montana Demonstration Project to the extent possible. While these assessments will not be duplicated or continued unless specifically articulated, using the information as appropriate and possible ensures the effective use of public funds and maximizes the resources available through the demonstration project.

SAMHSA Assessments

The System of Care Assessment examines whether programs have been implemented in accordance with System of Care theory and documents systems development to meet the needs of youth and families.

Services and Costs Study: Describes the types of services used by youth and families, utilization patterns and associated costs. Of interest are: service use, service combinations, continuity or gaps in care and length of treatment. This study explores the relationship between service use, costs and outcomes. This data is required twice in the life of the grant; data collection is ongoing. The information gathered through this study could provide some useful benchmarks.

Sustainability Study: Captures information about factors that may impact system of care sustainability, and tracks community assessment of these factors and their impact. It's a web-based survey conducted by program directors at sites in years 3, 5 and 6

Treatment Effectiveness Study: This study involves selected communities and a randomized clinical trial to assess effectiveness of evidence-based interventions within systems of care. It

compares outcomes among youth receiving standard system of care services *plus* evidence-based treatment to those receiving standard system of care services alone. This information will be collected through longitudinal outcomes.

Primary Care Provider Study: Investigates the role of primary health care practitioners in newly funded systems of care and defines the impact of services provided within primary care settings on child and family outcomes. This web-based survey is administered to physicians.

The Cultural Competency Survey was created through a partnership with the Crow Tribe, Harrison Bach evaluators and the Children's System Of Care (SOC) Committee. This survey will be used to define technical assistance and training needs and to shape state and community efforts.

The Comprehensive Community Service Assessment will assess all existing traditional and nontraditional services to identify gaps in the service array, and will capture co-occurring capabilities and trauma services. This study is in process, and data is being collected in Billings, Missoula and the Crow Nation. The target date for completion is 10/31/2006.

– **Systems Integration Goals: AMP Montana Demonstration Project**

Goal 1: To develop and coordinate an integrated, culturally competent service support system for youth between the ages of 6 and 16 with SED, living in, or about to be placed in, an out-of-home setting, who need multiple services from a variety of providers.

Goal 2: To ensure the availability of wraparound, culturally competent, child- and family-centered home- and community-based services for youth with SED and their families through the creation of local continuums that include a wide cross-sector of child-serving systems, including, but not limited to, mental health, child protective and chemical dependency services, local schools, local juvenile detention and probation, and the medical community.

Goal 3: Continue to engage parents and families in designing the service system at two levels – through family-directed treatment plans, and by providing input through Montana's Administrative Rule Process (2-3-103, MCA), which encourages, ensures and assists public participation in agency decisions and before action is taken. See Appendix 5: Administrative Rule Process.

Progress toward systems integration goals: Systems integration is a long-term priority in Montana, as evidenced by the Children's System of Care Committee (SOC) and the requirement for a Multi-agency Memorandum of Understanding (52-2-303 MCA) passed by the 2003 Legislature. The SOC is charged with developing and coordinating an integrated service support system for youth with SED under age 18, who have multiple service needs and are living in or about to be placed in an out-of-home setting. The Committee is comprised of State DPHHS mental health, child protection, developmental disabilities and chemical dependency treatment bureaus. Additional members include the Office of Public Instruction; the Department of Corrections; the Youth Justice Council and the Montana's youth courts. The DPHHS Director may appoint others, including families, providers and/or agency representatives. As the Single State Agency for Medicaid, DPHHS is in a unique position to make these appointments. The committee is highly inclusive and has approximately 30 members, including youth with SED, Native American stakeholders, advocacy groups and health providers. (SOC Legislation: Appendix 3.)

Cultural Diversity: This system is client- and family-centered and family-directed, which brings culture down to the individual family level. Since families will guide the processes and supports to include in the treatment plan, they will be able to ensure a good cultural fit. Approximately a quarter of those served in PRTFs are American Indian youth. Cultural competency in context

with the diverse American Indian cultures served will be an integral part of the demonstration. Technical assistance in cultural competence for providers and others has been available through the SAMHSA grant from the In-Care Network, Inc. project (the cultural consultant/trainer for the SAMHSA grant). *In-Care*, derived from the phrases *"*Indians who care*"* and *"*Individuals who care," holds culture as a way of life and utilizes the Medicine Wheel as a framework for treatment. Their *Two World Model* believes in restoring balance rather than treating dysfunction.

3. Demonstration Design and Development: Describe how you will meet the statutory and regulatory requirements governing administration and operation of a section 1915(c) waiver addressing comparability, Statewideness, income and resources for the medically needy. Montana will meet statutory and regulatory requirements of a 1915(c) waiver governing administration and operation. Entrance into the Demonstration will be controlled by programming in the eligibility and reimbursements systems. (See Flow Chart, Appendix 14.)

A waiver of Comparability is requested. Provisions of the 1915(c) waiver to Section 1902 (a)(10)(B) of Title XIX allow states to make waiver services available to specific target populations, without making them available to the general Medicaid population, and to cap the number of participants. The target population for this project will be youth with SED who meet the requirements for an institutional level of care and who fall between the ages of 6 – 16. The unduplicated number of PRTF Demonstration Project participants will be capped at 20 the first year, 50 the second year, and 100 for years three, four and five.

A waiver of Statewideness is requested. Provisions of the 1915(c) waiver to Section 1902(a)(1) of Title XIX permits states to target waiver programs to specific areas where need is greatest, certain types of providers are available and to phase in implementation of programs. The PRTF Demonstration Project services will *not* be available statewide, but will initialize in Yellowstone County (Billings), to be followed in subsequent years with Missoula, Lewis and Clark, Silver Bow and Cascade counties. These counties encompass Montana's largest urban centers and are home to the largest populations of youth with SED who meet the institutional level of care.

A waiver of income and resources requirements for the medically needed is *not* requested. Montana will continue to apply standard income and resource restrictions to the youth and their families, but will use the waiver to create the flexibility in funding necessary to provide home- and community-based services as versus in a PRTF.

4. Participant Recruitment, Identification, Retention (See Flow Chart, Appendix 14)

i. Describe the intended target population: Medicaid-eligible youth between the ages of 6 – 16 who meet the criteria for SED, and demonstrate such complex health and mental health needs that they require a PRTF level of care or are at imminent risk of admission to one. Eligible youth will have a viable and consistent living environment with parents, guardians or caregivers willing and able to participate in the demonstration grant.
ii. How the target population will be identified: Youth who appear to meet the demonstration project criteria can be referred to the project by a variety of referral sources. All referrals will be reviewed by the Department's Utilization Review (UR) contractor, which will determine whether the child or youth meets the certificate of need requirements for residential treatment center placement.
iii. How the target population will be recruited: Once a child or youth with SED has made it through steps i and ii, the Child Behavior Checklist (CBCL) will be administered. If the score falls within specific parameters (to be determined), the child and family will be approached

with the opportunity to participate in the *Montana Medicaid Alternative to PRTF Demonstration Project*. The parent can opt out, or choose to participate.

iv. How the target population will be retained. If the family chooses to participate in the demonstration, a Treatment Plan Manager will be assigned to help the family create a treatment plan and attach a cost to the plan. One significant retention strategy is the delivery of family-centered, family-driven treatment. The Treatment Plan Manager will work with the family to ensure that they receive the services and supports needed to maximize the child's chances being maintained in the home and community. The family can remain in the program until they meet opt out or meet discharge criteria. Some discharge factors under consideration are: monetary or time caps; until medical necessity no longer exists; and change in CBCL scores. The Treatment Plan Manager (TPM) has a very low case load, so the family will have access to plan management services with minimum weekly contact. The TPM will arrange services, coordinate efforts with the local KMA and monitor and review eligibility at 30 days.

v. Eligibility criteria for admission to the AMP Montana Project: The youth is between ages 6 and 16; Medicaid-eligible; meets criteria for SED; meets Certificate Of Need requirements for an institutional level of care as determined by the Department's Utilization Review Contractor; has CBCL scores within a pre-specified range; has parents or caregivers willing and able to provide a stable home; child and family agree to participate in the demonstration.

– Montana's Level of Care Assessment (the CBCL) has been included in Appendix 6.
– Letters of Commitment: The Yellowstone County KMA will assist in a variety of ways. A letter signed by 13 of its members, and a Memorandum of Understanding have been included in Appendix 7.

5. Describe the intended service delivery approach, services and supports offered to participants. Provide the rationale (including research results) for services not listed under HCBS in Attachment #6. Discuss how services will be culturally appropriate to enrollees.

Service Delivery Approaches: Montana will continue delivering service using a *system of care* approach, which relies on local partnerships comprised of families, mental health, education, child welfare, juvenile justice and other child-serving agencies. These systems are developed around core principles that include child-centered, family-driven, strength-based, culturally competent, with support from strong local interagency collaborations. Teams work together to provide wraparound care for youth who meet the criteria of SED, as well as support for their families. Care includes the mental, emotional and behavioral services and supports to succeed in the community. Individualized service plans are family directed and client centered, building on the unique strengths of each child and family. Individualized service plans are consistent with the family's culture and language. Montana's approach to the Home- and Community-Based Demonstration Project will include therapeutic teams consistent with those described, which work with the family on a regular basis.

Services and Supports for Participants: Individualized treatment plans will draw from a menu of the services and supports detailed below. Every service available will not be needed by every family, but all – in addition to all other regular state plan services that Medicaid provides – will be available to demonstration project participants. Each service and support package will be based on individual need. The Plan Manager will work with the family to create the family-directed, wraparound services needed to maintain the child/youth in the home or community.

Crisis Response includes crisis and safety assessments, intervention and consultation when a mental health crisis occurs. Mental health crisis intervention services will offer 24-hour avail-

ability on a face-to-face, short- term basis for intensive mental health services initiated during a mental health crisis or emergency. Services help recipients cope with immediate stressors, identify available resources, and begin restoring the recipient to his/her baseline level of functioning.

Respite Care provides services for family members/regular caregivers in the form of temporary, short-term relief. Respite care can be provided in or out of the child's home, and will be provided by a respite provider working for a mental health center or an appropriate family choice.

Education and Support Services will be available to unpaid caregivers, including such things as instruction on the diagnostic characteristics and treatment regimens (including medication and behavioral management) for the child or youth they care for. Caregivers will be taught new skills and given information that will enable them to understand and cope with the dynamics of their child's illness. Training includes updates as necessary to safely maintain the child at home.

Medication Management Services provide a professional integrated review and assessment of all medications the child may be taking, and a review of the medication that could most effectively alleviate diagnostic and behavioral symptoms. As appropriate, this service may be provided by a pharmacist.

Pharmacogenetic Screening will be offered to every child in the demonstration project. This cutting-edge screening enables professionals to provide definitive diagnostic information on the individual's ability to metabolize certain drugs.

Nonmedical Transportation enables participants to gain access to waiver and other community services, activities and resources specified by the individual service plan. Transportation will be available to caregivers for such activities as treatment team meetings, the child's medical or therapy appointments, social, recreational and spiritual activities. Nonmedical transportation must be included in the treatment plan. Participants will be encouraged to access this transportation through other sources, and to use nonmedical transportation as a last resort.

Consultative Clinical and Therapeutic Services will assist pediatricians and other primary care practitioners assisting the family and child in carrying out individual treatment/support plans by providing consultations with psychiatrists. This service is specifically designed to provide psychiatric expertise in terms of diagnosis, treatment and behavior management.

Flexible funding will be available for each family to accommodate services not typically provided by Medicaid. $200 is available per family for such things as socialization and enrichment opportunities specified by the individual service plan. Services will help youth and families deal with the stressors inherent to SED.

Rationale: With the exception of Pharmacogenetic Screening, all services selected for use in this demonstration project are listed under the HCBS list in Attachment 6 of the RFA. Pharmacogenetic Diagnostic (Cytochrome p450) testing enables the provision of definitive diagnostic information on an individual's ability to metabolize certain drugs. Many psychiatric medications are impacted by Cytochrome p450 status, and draft recommendations from health organizations are beginning to recommend the Cytochrome p450 test before prescribing certain drugs with dosing protocols based on results. It is common for youth with SED to be on multiple psychiatric medications, and psychiatric medication protocols have not been established for pediatric patients. Seven of the top ten medications (by cost) prescribed for Medicaid patients are impacted by Cytochrome p450 status. Testing project participants may improve the efficacy of prescribing and dosing. This practice is projected to improve patient outcomes and reduce cost of care.

Research base: The practice of pharmacogenetics has received FDA approval for clinical psychiatric practice of the AmpliChip CYP450 Test that genotypes for two cytochrome P450 2D6 (CYP2D6) and 2C19 (CYP2C19) genes. CYP2D6 is important for the metabolism of many antidepressants and antipsychotics; CY2C19 is important for some antidepressant metabolism. Poor metabolizers account for up to 7% of Caucasians for CYP2D6; these phenotypes (particularly PMs) are probably important in patients taking tricyclic anti-depressants, venlafaxine, typical antipsychotics and risperidone. (Source: (Psychosomatics 47:75-85, February 2006. Academy of Psychosomatic Medicine.)

Cultural Appropriateness: A family-specific approach is imperative to cultural appropriateness in this project, and is largely achieved as a result of family- and youth-directed services. Cultural sensitivity to *all* families is the cornerstone of the AMP Montana project. There is significant diversity among the tribal nations of Montana and acculturation varies dramatically by tribe and locale, which compounds the importance of the family-specific approach. The In-Care Agency currently provides statewide technical support around cultural competence through the Two Worlds Model through Montana's SAMHSA grant. Those involved in serving clients through the demonstration project must understand and value the premises behind cultural competence, parent-professional collaboration and a strength-based versus deficit-based models for services.

– Montana's Level of Care Assessment has been included In Appendix 6.

6. Systems Quality: Describe the approach to quality of care. How will you ensure service model fidelity through implementation and operations. How will utilization data be used to determine benchmarks for functional outcomes and quality improvement?

Approach for quality of care: Quality Management is critical to determining whether the project is operating in accordance with the program design, meets statutory and regulatory assurances and requirements, is achieving desired outcomes and identifies opportunities for improvement. Systems quality strategies will be applied to create a continuous evaluation loop so that the project can be improved on a global level through mid-course corrections or remediation, and on an individual, family level to ensure retention and satisfaction.

Ensuring service model fidelity through implementation and operation: Montana is currently engaged in a comprehensive systems assessment through the SAMHSA Systems of Care Assessment, which looks at fidelity on an overarching scale. It will be conducted at three points in time throughout the life of the 2004 SAMHSA grant. On the family level, service model fidelity will include evidence-based measures at specific points in time Montana maintains a database of services received by Medicaid clients and is able to determine diagnosis, type of service and provider, amount and date of service, and general client demographics. Using that database, it will be possible to compare services received by youth and their families in the AMP Montana project. The CBCL, to be administered upon admission, and every six months, will provide information about clinical issues and changing functional levels. These tools and the ongoing involvement of the Treatment Plan Manager will ensure that families are following treatment plan protocols.

Service utilization data used for determining benchmarks for functional outcomes: Quality management geared to enhancing functional outcomes will be conducted through thorough, multi-pronged evaluations, including family reports, client satisfaction surveys and service utilization data. All data collected will become part of a feedback loop to systems-level partners, providers and families. Treatment Plan Managers will use the data to respond to the needs of their clients, and to adjust or augment the individual care plan as necessary.

Service utilization data will be used to determine benchmarks for functional outcomes in two ways. Those served will meet an institutional level of care, so avoidance of residential care and maintenance in the home or community will be tracked individually and collectively. Aggregate service utilization data from the MMIS (Medicaid Management Information System) for those served by in- and out-of-state PRTFs will also be used to determine benchmarks against which to measure individual and aggregate outcomes of participants. This data will provide a framework for quality improvement activities. Ultimately these tools will enhance the capacity of the Medicaid system to evaluate the impact of the home- and community-based services provided.

7. Provider Requirements: Describe how the Applicant will ensure that service providers meet requirements. Include any training necessary and how training will be delivered.

"Qualified Providers" are legal entities established under the Montana law and determined by the Department to be qualified to provide supports to a waiver-enrolled individual. Montana will ensure that providers meet requirements, in part, by maintaining and enforcing existing Medicaid requirements. Signing the application to enroll in Montana Medicaid denotes compliance with the conditions of participation as defined by the Administrative Rules of Montana (ARM), defined under ARM 37.85.401 – 37.85.402 (Appendix 8). Some of the requirements include: the provider must be enrolled in Medicaid; services must be performed by practitioners licensed and operating within the scope of their practice as defined by law; the service must be covered by Medicaid and/or the demonstration waiver; the service must be medically necessary as defined by the demonstration waiver and/or Medicaid requirements; and prior authorization requirements must be met. The Department of Public Health and Human Services may review medical necessity at any time before or after payment; providers must make all medical records available to the Department and all services must be a part of the medical record. The Department may withhold payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies. Requirements for the provision of each service under the AMP Montana Demonstration Project, including licensure, regulations and State Administrative Rules (ARM) will be specified during the implementation planning phase. Most standards will be addressed under uniform State citations.

Necessary Training and Training Delivery Mechanisms: Anyone affiliated with the AMP project will be required to meet current ARM Training Requirements for the specific program or services provided. Training specific to the Demonstration Project will be provided by licensed or certified trainers or a provider that employs a certification process.

8. Implementation Plan: How Montana will approach the IP development process, including outline of the implementation phase and description of proposed goals and objectives

Montana will approach Implementation Plan development through an inclusive process that convenes stakeholders at state and local levels. The AMP Project Director will present the components of the demonstration project as proposed and services to be delivered, and elicit public opinion from a variety of sources, including the Yellowstone County KMA, other care providers and child-serving agencies, families, youth with SED and other interested parties. The AMP Demonstration will begin in Yellowstone County, then move to a second of the proposed counties starting in Year 2, and to the remaining counties in Year 3. The Children's Mental Health Bureau (CMHB) and Health Resources Division (HRD) of the Department of Public Health and Human Services will manage the grant and be responsible for conducting all activities necessary to meet the goals and objectives of the grant, including planning and implementation. The Department's Utilization Review contractor, evaluation contractor, AMP Manager, parents and

other community partners will all play key roles in developing the implementation plan.

Step One: The Project Director will convene facilitated sessions geared toward achieving systems integration through the AMP Montana Implementation Plan. The core concept of the plan will be presented and input will be elicited. State-level partners, including but not limited to CMHB staff, HRD administration and staff, SOC members, parents, tribal representatives, the Montana Mental Health Association, Parents Let's Unite for Kids (PLUK), and other interested parties. Outcomes: measurable objectives, tasks, timelines and responsibility centers for the overarching, systems level goals.

Step Two: The Project Director will convene facilitated planning sessions, to include members of the Yellowstone County KMA, additional family members, parents, youth, advocates and other child-serving agencies. The Project Director will present the core concept of services and proposed rules for the Demonstration. This group will provide suggestions for improvement, strategize creation/implementation of AMP teams, help define gaps and help ensure that the services necessary to maintain youth in the community are in place. This group will help define how AMP will coordinate with and compliment local efforts and create sustainable, ongoing roles for all partners. Outcomes: measurable objectives, tasks, timelines and roles.

Step Three: The CMHB and HRD will work with the Department's Utilization Review contractor to create detailed guidelines and protocols needed to select AMP participants, enroll providers for the demonstration, recruit participants, and measure functional outcomes. The CMHB and HRD will also work with the Department's Evaluation Contractor to ensure that the appropriate Information Systems and evaluation mechanisms are in place.

Preliminary Goals and Objectives to Address During Implementation of AMP Montana	
Overarching Goals	**Objectives**
Preserve families and prevent youth with SED from entering PRTFs by offering home- and community-based alternatives in the least restrictive placement closest to home.	1. Identify community partners and define their roles in the Demonstration. 2. Create detailed criteria (including placement scores) for inclusion. 3. Define the AMP referral process and acceptance into the project. 4. Enroll and track 20 Yellowstone County youth with SED Year 1. 5. Measure progress and outcomes for those served; use results to make midstream corrections in the process before moving the project to another county. 6. Year 2: Enroll and track 50 youth. 7. Years 3 – 5: Enroll and track 100 youth served. 8. Measure success in terms of functional outcomes, cost effectiveness and neutrality on an annual basis and for the life of the project.
Develop and coordinate an integrated, culturally competent service support system for youth living in, or about to be placed in, an out-of-home setting.	1. Create a local asset map identifying all state and local agencies and other unofficial supports (including faith community and intramural activities) that could be brought to bear in a wraparound service approach. 2. Note service gaps, and seek creative ways to fill those gaps. 3. Create protocols for service packages consistent with Demonstration principles. Define roles and responsibilities for maintaining the family in the demonstration and the child in the home.
Make wraparound, culturally competent, family-centered HCBS available for youth with SED and their families.	1. Strengthen local continuums of care to include youth, families, youth-serving systems including mental health, child protection, chemical use/dependency services, local schools, juvenile detention/probation, and medical community. 2. Define the most effective ways to create individualized child- and family-centered AMP teams while avoiding duplication of efforts.

Engage families in system design through family-directed treatment plans and the Administrative Rule Process.	1. Define the mechanisms necessary to ensure that feedback from AMP staff, service recipients and providers reaches the CMHB, HRD, Medicaid, the Department's Utilization Review and Evaluation contractors. . 2. Encourage and assist participation in the ARM Rule Making Process to ensure that local and parental feedback is integrated into policy.

9. Information Systems (IS): Describe any IS changes needed to implement the program.

Two systems are in place. The Medicaid Management Information System (MMIS) manages all Medicaid claims. It is a web-based database housing items including cost, units, service type, procedure codes, diagnosis, county of residence, gender, ethnicity age and eligibility.

The Department's evaluation consultant is currently under contract through the SAMHSA grant to develop a web-based information database, the Kids Integrated Data System for Montana (KIDSfm), designed to accomplish three objectives:

1) Track, maintain and share a comprehensive collection of client service records in order to provide a more effective system of care at the local level;
2) House data collected from the SAMHSA National Evaluation so that it can be used at the local level presuming proper releases are in place. This includes all of the instruments we are using for the demonstration project evaluation. Adding this evaluation to the database may require some system enhancements.
3) Develop treatment plans and strategies, including costing services. During the implementation phase, the services that will be offered will be added to the database. The Treatment Plan Manager will then be able to utilize the database to monitor youth, write case notes, treatment plans and to run individual and aggregate reports.

The KIDSfm database was built for Montana to collect information required for the national SAMHSA evaluation. There are no issues tied to licensure, monthly fees or number of users. The agreement provides unlimited use and joint ownership of the product, and data can be downloaded to the SPSS system, and data-collection requirements tied to the Demonstration project can be incorporated. Modifications will, however, be needed.

Modification will also be necessary to the economic assistance management system, CHIMES, formerly known as TEAMS. This system contains information on the client, case, and federal program for cash assistance, food stamps, Medicaid, and child care. Based on data entered from a client's application, this system calculates the appropriate benefit amounts. The system will require extensive programming modifications to accommodate the demonstration project.

10. Technical Assistance Plan: Identify any areas/activities, for which technical assistance (TA) is required, the process for acquiring technical assistance (e.g., contract), the technical assistance entity, and a detailed budget for procurement of technical assistance.

Areas/activities for which TA is required: Technical assistance will be needed for the adjustments to the MMIS and CHIMES information systems, as noted above. Enhancements will be needed to accommodate the information needed for the Demonstration; and AMP evaluation services. CHIMES will specifically need changes to reflect the eligibility criteria for the AMP Demonstration, including a distinct "deprivation code." The enhancements will be Year One investments. Technical assistance will also be required from the Department's evaluation consultant, to ensure that the right tools and mechanisms are in place for an effective evaluation. Additional technical assistance may be required from specific provider types to create the steps for implementation of the various services planned, e.g., Pharmacogenetic screening.

Process for acquiring TA: Technical assistance needed for the demonstration project will be acquired on a contract basis, and purchases must abide by procurement policies established by and for the State. Specific procedures are based on the estimated value and type of commodity. If the estimated value of a purchase is $5,000 or less, the agency may purchase directly from a vendor (unless the purchase involves printing or specific controlled commodities). If the estimated value is between $5,001 and $25,000, the agency may purchase the item based on an informal documented competition. If the estimated value exceeds $25,000, a formal competitive method must be used to procure the item. A *Request for Proposal* is typically used for complex procurements and is used when a state agency needs to consider factors in addition to cost.

Identify the technical assistance entity: Montana must abide by standard procurement policies for any contracted services. There is no way of knowing prior to announcement of availability of the contract who will submit bids for services.

TA Procurement Budget	Year 1	Year 2	Year 3	Year 4	Year 5
Evaluation Consulting Services	$66,667	$80,000	$84,000	$88,200	$92,610
MMIS/CHIMES Enhancements	$400,000	$ -	$ -	$ -	$ -

11. Stakeholder Involvement: Describe how you will involve stakeholders in the Development and Implementation Phases of this demonstration, and through the life of the grant. How stakeholders will be involved in the Development Phase: Stakeholders, including parents, family members, youth and advocates, are the cornerstone of the Systems of Care model. Input from these groups has been and will be used to shape the AMP Montana Demonstration. An initial step will be hosting a facilitated session that brings local stakeholders together for input on the Demonstration strategies planned. The CMHB relies on the use of local continuums inclusive of parents and the services needed by youth with SED and their families and KMAs, must include parents, youth and families as 51% of their membership. Engaging families helps ensure that systems are effective. Families and other stakeholders will also be engaged in developing the formalized system through Montana's Administrative Rule Process. Additional mechanisms will include eliciting feed back through METNET, a telecommunications delivery system that has the capacity to link communities in real-time. The Department's website has capacity to solicit comments from the general public. All phases of the proposal will be posted on the Department's website, with an automated response form to the Project Director. Comments and responses will be posted online. Please see letters of commitment and support, Appendix 9.

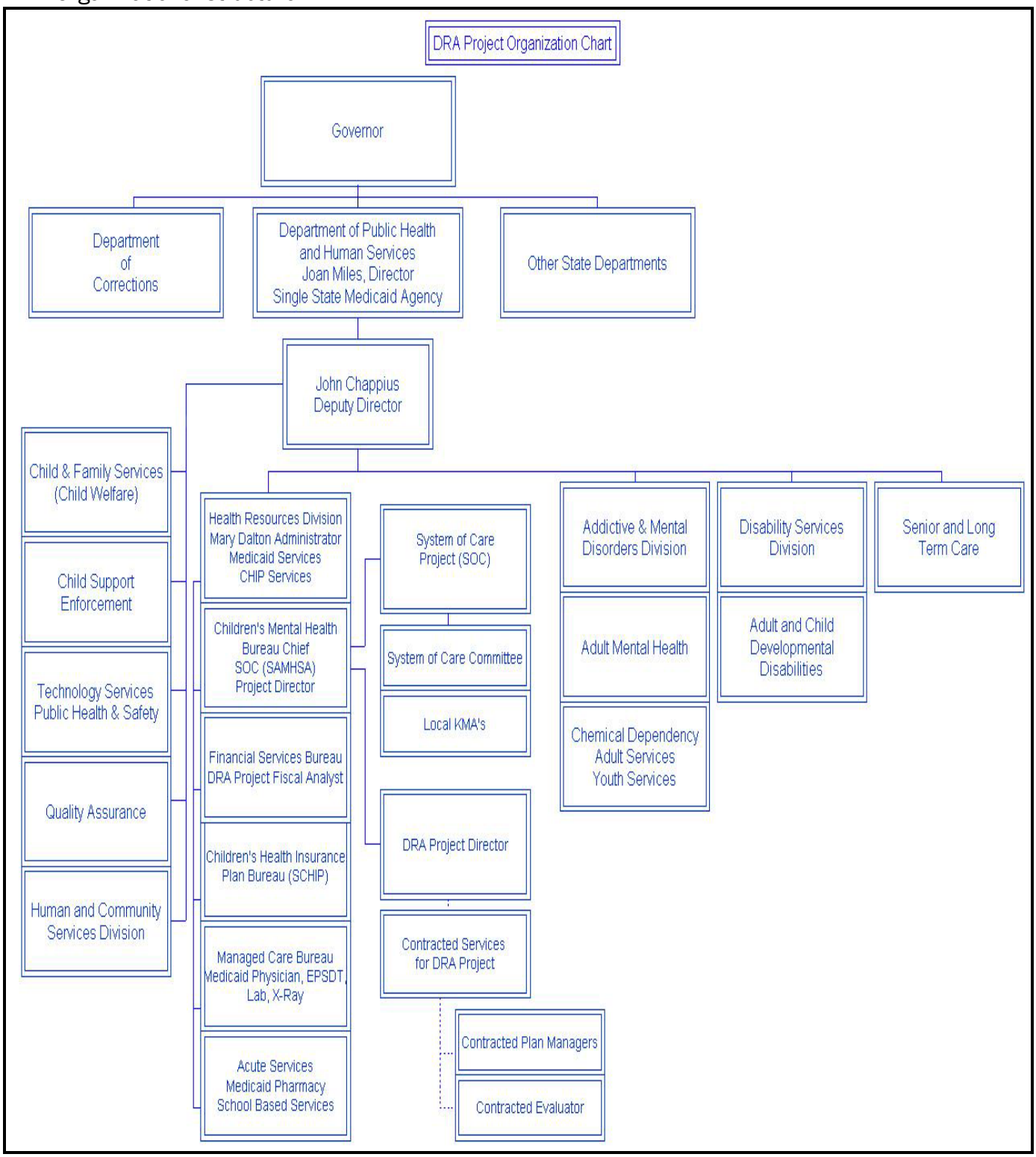
How stakeholders will be involved in the Implementation Phase: Individualized care plans for youth are family driven, involving stakeholders intimately in the Implementation Phase of the project. Addition, input will continually be elicited from KMAs, family reports, client satisfaction surveys, and client service utilization data will all be factored into implementation, individual family and midstream corrections to the project. A continual feedback loop involving all major stakeholders will ensure that the system is responsive to those it serves.

Describe how stakeholders will be involved: Stakeholders will continue to be involved throughout the life of the grant in the capacities described above, as well as through involvement in providing feedback on care needed and received and overall efficacy of the system to Treatment Plan Managers, CMHB and HSB staff, Utilization Review and Evaluation consultants.

12. A Statement of Assurance is included in Appendix 10. It provides Montana's assurances that all necessary safeguards necessary to protect the health and welfare of youth receiving home and community-based care under the auspices of this demonstration project will be in place.

Part C: Organizational and Staffing Plan

1. Organizational structure



2. Staffing Plan

The staffing plan detailed below will provide sufficient support for successful implementation of a sustainable project.

AMP Montana Demonstration Project FTEs	
Dedicated Positions	**% FTE**
– Project Director	100%
– Fiscal Specialist	50%
Key Staff Assigned to the Grant	
– Human Resource Division Administrator	5%
– Children's Mental Health Bureau Chief	5%
Contract Positions	
– Treatment Plan Manager(s)	100%
– Evaluator	100%

Roles and Responsibilities

Project Director (1 FTE)
The Project Director (PD) will be located within the Children's Mental Health Bureau and responsible for directing and managing the AMP project. The PD will ensure that implementation remains within legislative and federal grant guidelines and appropriation levels. The PD will work closely with the Children's Mental Health Bureau Chief, other Health Resources Division Medicaid and SCHIP program staff, Department of Public Health and Human Services divisions (e.g., child welfare, chemical dependency and adult mental health), other state agencies (e.g., the Office of Public Instruction and the departments of Justice and Corrections) and local project sites. The PD will identify challenges to successful implementation and coordination, and recommend corrective action. The PD will ensure opportunity for input on services, access and project evaluation. As needed, the PD will assist stakeholders with participation in the Administrative Rules Process. The PD has oversight responsibility for all contracts issued for the project.

The PD will also research available resources, policies, rules and other payer programs to determine need for changes, rules or policies to support implementation and evaluation. The PD will monitor multiple information sources for project budget and utilization, determine the validity of data and identify anomalies. Additional responsibilities include: recommending comprehensive strategies to ensure efficient operation; developing goals and objectives, work plans, and procedures; coordinating teams to ensure practice and policy changes are carried out; responding to requests for information; presenting testimony and preparing communication for regulatory, legislative and federal agencies.

Fiscal Specialist (50% FTE)
The Fiscal Specialist (FS) will be located within the Financial Services Bureau of the Health Resources Division. The FS is responsible for financial and policy analysis, utilizing knowledge of applicable state and federal rules, regulations, policies and laws, as well as the objectives of other project, bureau, division and departmental programs. This knowledge will be used to identify issues and propose solutions for best use of project funds. The FS is responsible for data analysis to complete federal reporting requirements, including projections to assist the PD in managing the project within the allocated budget. The FS coordinates with other Department fiscal bureaus to that ensure policies, rules, and project expenditures comply with federal and state rules and policies. The FS prepares reports as requested, accesses the DPHHS accounting systems to prepare reports, and provides assistance to ensure completion of evaluation reports on the project.

Health Resources Division Administrator (5% FTE)
This key staff position is responsible for the management of the various Medicaid service programs operated by the Division, including the AMP Montana project. The Administrator supervises all bureaus within the Division, including the Children's Mental Health Bureau. Approximately 5% of this position's time will be dedicated to supervision for this project.

Children's Mental Health Bureau Chief (5% FTE)
This key staff position is responsible for the management of the children mental health programs which includes both Medicaid and SAMSHA system of care project. The DRA project is the responsibility of this Bureau and the Bureau Chief provides direct supervision to the Project Director for the DRA project. Approximately 5% of this position's time will be dedicated to supervision for this project.

Treatment Plan Manager (100% of time is spent on DRA project)
This contract position will be located within the local site. The Project Director will oversee the contract. This position is responsible for managing the individual treatment plans for enrolled youth. These duties include: coordinating treatment team meetings to design and implement treatment plan services; monitoring compliance with the treatment plan; establishing eligibility and periodic review of youth eligibility for the project; coordinating with various community and state representatives to ensure compliance with project standards, values, policies, and financial limits; obtaining treatment plan and service cost from the Project Director; and administering various evaluation tools per instructions and guidelines of the Project Director. This position maintains face-to-face contact with the youth and family; advocates for the youth as needed; assists the youth and family with attaining the skills, knowledge, and ability to self manage, provides services to maximize youth and family independence from the project. This position provides feedback to the Project Director on local implementation of the DRA project and its challenges. The Treatment Plan Manager will suggest solutions, and provide information, including entry of information into databases identified by the Project Director.

Project Evaluator (100% of time is spent on DRA project evaluation)
This contract position is located outside the Children's Mental Health Bureau. The Project Director oversees the contract. This position is responsible for conducting the evaluation set forth in the project evaluation plan. The Project Evaluator gathers and analyzes data, provides feedback to improve implementation, prepares responses to federal and state inquiries, prepares draft reports for the project, identifies challenges and suggests solutions, administers various data collection tools, serves as a liaison with the federal evaluator as appropriate, provides training and technical assistance to facilitate successful implementation of the project and completion of the project evaluation.

Part D: Evaluation Plan

1. Briefly describe the evaluation design proposed for the demonstration.

Evaluation Design: The goal of the AMP Montana evaluation will be to thoroughly understand the conditions needed to maintain youth with SED in the community and to avoid PRTF placement, with an emphasis on youth functionality. The evaluation will include a cost component to ensure cost effectiveness, as measured by comparing the cost of services to the youth in the AMP project to the control group who access PRTF services. Level of care determination and cost effectiveness reviews will be done on demonstration participants every 30 days.

Montana plans to provide community-based service alternatives for youth at risk of placement in PRTF. The evaluation will test the effectiveness of providing home and community-based services in terms of improving or maintaining a child's functional level and the cost effectiveness of providing alternative, home and community-based services for youth enrolled in the Medicaid program under Title XIX.

Non-experimental design model: The evaluation will employ a non-experimental design with two groups: 1) youth in the Montana AMP project, and 2) a comparison group of youth being placed in PRTF. Members of the two groups will be matched on age, gender, diagnosis, and the scores derived from Child Behavior Checklist (CBCL).

The Evaluation Design follows, but refinements will be made during the implementation phase to ensure consistency with the evaluation requirements of the national project. Youth and families in the AMP project will complete the following instruments at intake and every six months until discharge: the CBCL, the Behavioral & Emotional Rating Scale- Youth Rating Scale (BERS-2Y), GAIN Quick R Substance Dependence Scale. Youth and families will be given the Youth Services Survey For Families (YSS-F), which will be administered by the evaluation contractor by telephone six months after entering the demonstration and at the end of each six months period thereafter until discharge. These tools were selected for their appropriateness with the service population, and because they have demonstrated good reliability and validity. The BERS, GAIN and YSS are included in Appendix 11; the CBCL is included in Appendix 6. Detailed information on validity, appropriateness and reliability has been included in Appendix 12.

Similar data will be collected on the matched group of youth who were placed in PRTF. Youth who are not served in the demonstration, but who enter PRTFs will be given the CBCL at intake and discharge. Through the Medicaid Management Information System (MMIS), we will track such variables as gender, age, diagnosis and cost. This information will enable Montana to modify the evaluation approach in subsequent years to further understand the issues families and communities face when working with youth at risk of being placed in PRTFs, as well as when they return to the community from PRTF placement.

During Year 1, the evaluation will gather qualitative as well as quantitative data. Qualitative information will be obtained through interviews with youth, family members and service providers. The Treatment Plan Manager, under supervision of the evaluation contractor will conduct in depth interviews of It will involve a review of past and current effects of various systems that impact the lives of the youth and families in key areas suck as mental health, school, juvenile justice, family functioning and environmental variables. The Treatment Plan Manager, under supervision of the evaluation contractor, will conduct in depth interviews. These will include a review of the past and current effects of various systems impacting the lives of the youth and families in key areas, including mental health, school, juvenile justice, family functioning and

environment. This data will highlight the variables important in maintaining youth in the community. Comparisons of participant and comparison groups on variables obtained from the instruments identified above and information gained through the qualitative interviews will reveal the differences between the study participants and youth in the comparison group.

Evaluation data will be collected from state agency databases, interviews with collateral agencies, families and youth. The data will be stored in the department's MMIS database and the Children's Mental Health Bureau's Kids Integrated Data System for Montana (KIDS*fm*).

– Provide evidence that the pool of potential demonstration participants within the proposed project area is adequate to provide for a project that will reach valid conclusions.

Initially, there will only be 20 participants in the Demonstration, to be increased to 50 in Year 2, then 100 in Years 3 – 5. There may not be great enough numbers the first year to ensure validity as based on quantity. However, the data collected will provide a very rich look at the service population and the intervention strategies, which should yield confident results. Use of a combination of qualitative and quantitative evaluation methods on the 100 participants in the Montana AMP will provide sufficient data from which to draw valid conclusions about the youth at risk of placement in PRTFs, particularly in view of the fact that 100 participants reflects roughly 20% of the State's entire PRTF population. The evaluation efforts for Years 2 – 5 will rely heavily on the variables determined during Year 1 to be most significant.

– Discuss any hypotheses to be tested in addition to those provided in the statute

There are currently no plans to test additional hypotheses.

– Discuss how the fidelity of proposed interventions will be maintained. The intent is to replicate this system in other Montana communities, if successful. In order to do so, the interventions must be well understood and delivered with fidelity. Each service will be thoroughly described in written format so that all providers clearly understand what is entailed in delivering the following services: 1) mental health crisis intervention services; 2) expanded respite care; 3) educational training about the diagnosis of the child and treatment regimens including medications and behavior management; 4) medication management; 5) non-medical transportation to enable waiver participants to gain access to community services, activities and resources, as specified by the service plan; and 6) consultative clinical and therapeutic services for diagnosis, treatment and behavior management. The evaluation will then carefully monitor the interventions to ensure that they follow specific fidelity guidelines.

2. Variables: describe the demographic, health care and functional outcome variables you propose to collect in the demonstration: A brief description of the groups of variables to be collected follows. A more complete list of the instruments and their reliability, validity, and appropriateness for use with SED youth and their families is contained in Appendix 12.

Demographic variables to be collected: date of birth, gender, race/ethnicity, youth's zip code, presenting problems, agencies the youth is involved with, funding sources and diagnosis.

Health Care: Medical diagnosis and treatment information will be collected through the MMIS database and tracked by the Treatment Plan Manager.

Community living: The living situation of study participants will be collected with the following detail: 1) days in PRTF, days in out-of-home placement, 2) days in home of choice, 3) days in psychiatric hospital, and 4) days in other out-of-home placement. These variables, along with the other demographic variables, will be collected upon intake for each youth in the study and will allow comparison by ethnicity/race, gender, age and other variables of interest.

School Functioning: The Treatment Plan Manager will have a close working relationship with the educational system and will collect the following variables at the end of each school term: 1) school attendance, 2) grade point average, and 3) number of disciplinary actions at school.

Juvenile Justice Outcomes: The ability to live successfully in the community is often a function of being able to avoid delinquent behavior and legal violations. The Treatment Plan Manager (TPM) will record 1) the number of contacts with law enforcement personnel, 2) number of arrests and 3) number of convictions every six months.

Family Functioning: A key need if youth are to remain in the community and at home is a supportive family/caregiver. The TPM must report any suspected abuse or neglect to the Child and Family Services Division. The TPM will log any abuse and neglect reports.

Alcohol and Other Drug Use: Dual diagnosis of substance abuse and SED will be documented by the TPM and monitored by measuring 1) decrease in alcohol and other drug use, and 2) decrease in exposure to alcohol and other drugs. This will be accomplished through the GAIN Quick R, which assesses use, abuse, and dependence of alcohol, marijuana, or other drugs. The overall alpha coefficient reported by Titus and Dennis (2004) for the 16 items of the GAIN for adolescents (using a 12 month timeframe) is .82; more information on reliability, validity and appropriateness and the GAIN tool are included in Appendix 12.

Mental health: The CBCL and the BERS-2Y will be used to measure 1) reductions in symptoms, 2) increases in cognitive functioning, 3) positive goal directed behavior including increased purpose in life, 4) sense of self-efficacy, 5) internal locus of control, and 6) reduction in suicidal behavior. The CBCL has good internal consistency and test-retest reliability. More information is included in Appendix XX. The BERS-2Y demonstrates adequate reliability, good test-retest correlation coefficients and inter-rater reliabilities between parent and students on each of six subscales. More information is included in Appendix 12.

Social support: Changes in the frequency and amount of positive friendships will be documented through the Social Competence Scale of the CBCL.

Program satisfaction: Family and child satisfaction. Wraparound child and family team satisfaction will be assessed with the Youth Services Survey, youth and caregiver versions (YSS & YSS-F). Collectively, these gauge satisfaction with services across domains (e.g., location, quality, cultural competency and participation in treatment). Based on a reliability analysis of the State Indicator Pilot Project, the Cronbach's alpha for the domain measuring access to services is .73, participation in treatment is .77, cultural sensitivity of staff is .91, satisfaction with services is .94 and perceived outcome of service is .91. More information is included in Appendix 12; the tool is included in Appendix 11.

Environmental variables: The family's ability to maintain stable housing, income and transportation will be assessed through an exit interview with the Treatment Plan Manager.

3. Minimum data set to CMS: The AMP project will comply with any data set reporting required by CMS. Montana understands that acceptance of the proposal does not necessarily imply that the proposed minimum data set will be accepted without modification.

Propose a minimum data set to be included in the quarterly report to CMS: Access to personal health information referenced in this document will be provided on a quarterly basis to CMS as long as sharing of information conforms to the requirements of HIPAA.

Montana, the CMHB, the HRD and the DPHHS, have exceptional track records with collecting, maintaining and analyzing data for evaluative purposes, and in compliance with federal grants. The data will be stored in three places, CHIMES, the MMIS and KIDSfm databases.